THE PRIMARY RESPONSIBILITIES OF THE MEDICAL SCHOOLS*

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THE most important responsibilities of a medical school, traditionally, have been the selection of medical students and faculty and the provision of facilities for the teaching, research, and patient-care activities of the faculty. Today society and communities are demanding that the schools change their standards and practices and take on many other responsibilities.

For example, consider the effects of community actions on medical school admissions. Increasing numbers of black and other minority students, women, and COTRANS† and Fifth Pathway‡ students are being admitted. Community splinter groups have been highly vocal and effective in influencing legislators to restrict state funds to schools which admit out-of-state residents and in forcing the admission of students who have gone abroad for their medical education. Federal legislation has been passed that requires schools to admit a certain number of residents of the United States who were enrolled in foreign medical schools, have completed two years of work, and have passed an examination.[1]

In recent years the Board of Regents of the State of New York has bypassed medical school admissions standards by licensing more foreign than American and Canadian graduates. The Board also will license medical students educated abroad who have never received an M.D. degree.[2] In addition, New York is still one of a minority of states that does not require any hospital training before licensure.

It must be admitted that the total number of newly licensed physicians in New York State has greatly increased—from 1,039 in 1960 to 3,807 in 1975. However, to my knowledge, none of these community and social actions on admissions and licensure has improved the competency or

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†Students who studied two years in a foreign medical school.

‡Students who studied four years in a foreign medical school.

quality of the graduates or has resulted in minority or underprivileged groups receiving demonstrably better professional care. Perhaps it is too soon to make such evaluations. In general, community interests appear to center on obtaining the admission to medical school of the sons and daughters of special-interest groups, with little regard for the quality and competency of the product coming out of the medical school.

Today, in our so-called "free society," a term which might be seriously questioned with respect to the future of the medical profession, the graduate is free to practice in any community and to care for patients of any race, creed, color, or sex at his discretion. As yet, the provisions of professional services by the physician is not limited to patients of the race, creed, color, or sex on the basis of which the student may have gained admission to medical school. In addition to changes in admissions practices, the schools are responding to at least three major thrusts forcing them to enlarge their responsibilities: 1) the assumption of the responsibility for the education of large numbers of health-related and other students, 2) growing responsibility for education and training beyond the M.D. degree and the continuing education of physicians, and 3) the expansion of activities related to service and the care of patients.

I shall talk briefly on the education of those who are not medical students and on postgraduate education. Table I shows two examples of the scope of the educational responsibilities of two schools, one state owned and one privately owned. One may note, first, that residents (including interns) approximately equal medical students in number at both schools. In fact, in New York State, hospitals affiliated with medical schools now account for some 85% of all residencies. Nationwide figures are similar, with an even higher percentage of all residencies in affiliated hospitals. President John S. Millis, chairman of the Citizens Commission on Graduate Medical Education, in his report on *The Graduate Education of Physicians*,[3] stated that "graduate medical education cannot and should not become entirely a university responsibility." The present trend certainly belies his statement. As is well known, the debate goes on today whether these young physicians are students, with their educational costs the responsibility of the medical schools, or hospital employees with rights to unionize. In spite of a National Labor Relations Board ruling that they are students, residents today strike because they desire to belong to a bargaining labor organization.

Two additional points might be made about Table I: 1) The number of

TABLE I. THE SCOPE OF EDUCATIONAL RESPONSIBILITIES AT STATE-OWNED (SCHOOL I) AND PRIVATELY OWNED (SCHOOL II) MEDICAL SCHOOLS. TWO EXAMPLES BY NUMBER OF STUDENTS

	School I	*School II*
Medical students (M.D.)	500+	400+
Residents	450	365
Pharmacy students	83	
Dental students	175	
Social-service students		10
Nurse-practitioner students		30
Nursing students	360	28
Arts and science students	810	158
Graduate students	190	284
Physical education students	100	
Medical technology students	120	
Cytology students		4
Fellows		66
Occupational therapy students	50	22
Continuing education students	1,756	1,287
Total	4,594+	2,654+

arts and science students taking courses in medical schools covers the range of the educational programs of the schools. 2) Considerable criticism has been levelled at the schools for failing to expand their responsibilities for continuing medical education. In 1974-1975 30,000 physicians registered for courses given by medical schools in New York State. (Some individuals may have registered for more than one course.) The faculty members of the 12 schools in New York State number 20,000, and many not only teach but also attend conferences and seminars, thus continuing their own medical education. Finally, it is of interest that the medical student provides 80% of all tuition income obtained by the schools. All other categories of students contribute less than 20% of total tuition income. The communities and society may be required to give better support for all the students who are not studying for an M.D. degree if the schools are to remain financially viable.

The third thrust producing a change in the responsibilities of the medical schools is the rapid expansion of their medical services through their hospital affiliations. Table II shows the growth of the services of the affiliated community hospitals in the United States since 1972.[4] Roughly more than one third of all inpatient and outpatient services in the nation were delivered by these community institutions. In addition to these com-

TABLE II. SERVICES PROVIDED BY ALL COMMUNITY HOSPITALS IN THE UNITED STATES AND BY THOSE AFFILIATED WITH MEDICAL SCHOOLS, 1972 AND 1975

	All community hospitals	*Affiliated hospitals*	*Percentage of national total*
		1972	
	5,746	467	8
Admissions	30.7 M	7 M	23
Outpatient visits	162.6 M	57 M	31
		1975	
	5,875	662	11.3
Admissions	32.7 M	10.2 M	31
Outpatient visits	189 M	81 M	43

M = million

munity hospitals, medical schools have affiliations with federal and state hospitals.

Table III shows similar data for all approved hospitals in New York State—not just community hospitals. In 1975 the affiliated institutions in New York State provided almost 45% of all inpatient and outpatient care for a population of considerably more than 18 million, which includes patients who come to these facilities from other states.

There are at least two reasons for the development of these affiliated hospital services, which appear to be of advantage to both schools and hospitals. During the last 50 or more years, medical schools and some of the major teaching hospitals have developed a model for the delivery of high-quality hospital care. The model was based on attracting a full-time and part-time clinical faculty which, working as a group, attracted and trained young physicians and incorporated new medical knowledge and techniques into the delivery of medical care. The public and communities generally recognized the competency of the staff and the quality of the services provided in these ivory towers. The staffs of community hospitals desire to share the prestige and services of the resident staffs of these teaching hospitals. They have begun to realize that a nucleus of full-time physicians is necessary to supervise residents and to organize teaching conferences and seminars. Many would like to delegate these responsibilities to the affiliated medical schools and have sought affiliations.

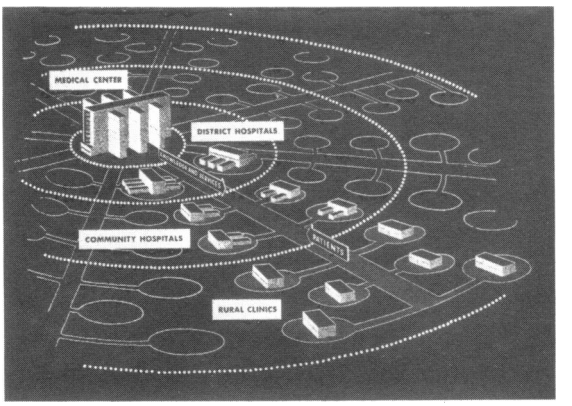
TABLE III. SERVICES PROVIDED BY ALL APPROVED HOSPITALS IN NEW YORK STATE AND BY THOSE AFFILIATED WITH THE MEDICAL SCHOOLS, 1972 AND 1975

	All hospitals	*Affiliated hospitals*	*Affiliated as percentage of all hospitals*
		1972	
	416	67	16%
Admissions	2.7 M	1.007 M	37%
Outpatient visits	23 M	5.8 M	25%
		1975	
	415	100	24%
Admissions	2.78 M	1.28 M	46%
Outpatient visits	26.5 M	11 M	41.5%

From a practical standpoint, the schools have been forced to seek expanded hospital facilities. Dr. Kevin Cahill, Governor Hugh Carey's chief health advisor, recently stated in a press interview[5] that affiliation agreements of the medical schools "will soon be expanded to include smaller voluntary and proprietary agencies throughout the state." By affiliation, the schools improve their public relations and, perhaps, weaken criticism that they fail to recognize their community responsibilities. All this is difficult to understand in light of the huge service obligations which medical schools have assumed through their existing affiliations. However, the schools have found it necessary to seek expanded clinical facilities for their teaching programs for a number of reasons: 1) their enlarged medical school classes, 2) the demand of foreign medical graduates for hospital training, 3) the new programs for general or family-practice clerkships and residencies, and 4) federal legislation which will compel the schools to increase primary-care residencies in those hospitals over which they have some authority for residency training.

Many affiliations have little to offer the undergraduate M.D. program. They may be used only for residency training in a specialty.

It is most difficult to measure the impact of affiliation on the quality of care provided for patients or on the quality of education and training. However, it is of interest that of the some 60 hospitals in New York State which were members of the Council of Teaching Hospitals (a division of the Association of American Medical Colleges) in 1970, 24 had 83% of



Plan for the nation's health system proposed by Federal Security Administrator Oscar R. Ewing, in 1948.[8]

their internships and 87% of their residencies filled by foreign graduates and there was no significant change in these house-staff patterns by 1975.[6] One might expect that with medical-school sponsorship and the exposure of medical students to the staff and residents in these hospitals that students would seek house-staff positions and that the number of American graduates on these staffs would increase. Apparently, the students were not impressed by the training opportunities offered.

Education is a slow process. I suspect that, with the increased output of American schools and changes in immigration laws limiting the number of foreign graduates entering the United States, eventually there will be a larger number of American graduates in these hospitals. Such change will depend on numbers and social changes, and not upon well-planned and intelligent efforts to improve the quality of the education and training in these institutions. Unless the schools control staff appointments, there is little they can do to improve the educational standards; thus, they should not be held responsible for the quality of medical care.

The vital issue is what role the schools should or must play in the organization, supervision, and actual delivery of medical care. Will they have any choice in this matter or will the responsibility be thrust upon them?

All the plans for the delivery of health care certainly involve the medical schools and centers. The Carnegie Commission report in 1970 on *Higher Education and the Nation's Health* recommended some 40 or more

health-science centers and 126 health-education centers administered by university health-science centers.[7]

The accompanying figure shows a similar design for a system of health-care delivery. This plan was presented to President Harry S. Truman in 1948 by the then federal security administrator, Oscar Ewing.[8] It was strongly opposed by the American Medical Assication and many educators who thought it too socialistic. It was believed that the rigidity of the blueprint would curb freedom of action and private enterprise. This program was presented some 20 years before the Carnegie report, but it was never mentioned in the Carnegie monograph.

Although some 30 years have passed and only limited steps have been taken relating to this program, today we appear to be taking rapid strides toward implementing such a plan. The medical schools with their affiliated community, federal, state, and city hospitals form the potential base of the system. How much responsibility for the care of patients can be assumed by or thrust upon the medical schools without submerging their teaching and research programs? Hospital affiliations require a great deal of time, effort, and thought on the part of the schools.

A new ball game is at hand for medical education. Great expertise and leadership will be required to guide the schools so that they may continue to provide high-quality medical education and, through research, help the community doctors and hospitals improve their services for patients.

REFERENCES

1. Health Professions Educational Assistance Act, Title V, 2C, 1976.
2. Qualifications of certain applicants for licensure. Section 6528, New York State Education Law.
3. Citizens Commission on Graduate Medical Education: *The Graduate Education of Physicians*. Chicago, Amer. Med. Assoc., 1966.
4. *Hospital Statistics*. Chicago, Amer. Hosp. Assoc., 1975.
5. Medical schools agree to wider exchange. *New York Daily News*, p. ML 7, September 14, 1976.
6. *Council of Teaching Hospitals Directory*. Washington, D.C., Assoc. Amer. Med. Colleges, 1970, 1975.
7. The Carnegie Commission on Higher Education: *Higher Education and the Nation's Health Policies for Medical and Dental Education*. New York, McGraw-Hill, 1970.
8. Ewing, O. R.: *The Nation's Health —A Ten Year Program*. Washington, D.C., Federal Security Agency, 1948. 1948.